1996 School Health Education Profile

▶ *Executive Summary and Key Findings*

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1996 Missouri School Health Education Profile

Executive summary

The School Health Education Profile is a survey conducted in the spring of even-numbered years, as part of a cooperative agreement between the Missouri Department of Elementary and Secondary Education and the federal Centers for Disease Control and Prevention (CDC). The first survey was conducted in Missouri in 1994, and results were reported in a document titled *Recommendations for Improving School Health Education and Reducing Health Risks for Missouri Students* (August 1996). This report highlights the findings of the second (1996) School Health Education Profile survey.

During the spring of 1996, questionnaires prepared by the CDC Division of Adolescent and School Health were sent to the principal and a designated lead health education teacher in 340 secondary schools in the state. Usable questionnaires were returned by 249 principals and 250 teachers.

The responses are representative of secondary principals and health education teachers in Missouri public schools, and results may be used to develop policies and improve programs for school health education, including HIV/AIDS prevention education.

Survey results were compiled in the following categories: (1) overall results for all schools; (2) for schools composed primarily of grades 9-12; (3) for schools composed primarily of grades 6-8; and (4) for schools composed primarily of grades 7-12. Not all data are reported in this summary. Key findings representing significant changes from the 1994 survey results are reported and discussed.

Key findings from 1996

Influences on Health Behavior

• The percent of principals who reported that their schools did not use trained peer educators increased to 68 percent compared to 50 percent in 1994.

• 75 percent of the teachers reported they include analysis of media messages in their health education instruction. (No data reported in 1994.)

Support for School Health Education

• School or district support for inservice training or staff development in health education increased, with 84 percent providing substitutes (58 percent in 1994) and 74 percent reimbursing expenses (58 percent in 1994).

• Schools with someone designated to coordinate health education increased to 90 percent from 71 percent in 1994.

• Teachers' attempts to involve parents in health instruction increased, with 57 percent including parents in homework assignments (39 percent in 1994) and 49 percent sending educational materials home to parents (28 percent in 1994).

• Schools with an active health education advisory council decreased to 41 percent from 46 percent in 1994. However, of those with a council, the composition changed considerably as shown by these percentages:

	1994	1996
Students	21%	67%
Parents	30%	92%
Teachers	42%	98%
School administrators	36%	97%
Food service staff	11%	32%
School nurses	24%	88%
Counselors	26%	73%
School board members	15%	49%
Public health dept. staff	9%	46%
Business community	8%	45%
Medical community	12%	59%
Mental health community	3%	18%
Churches or other religious organizations	7%	36%
Community-based organizations	9%	39%
Law enforcement organizations	NA	35%
Other	7%	22%

Amount of Instruction

• Required health education for students in grades 11 and 12 more than doubled to 24 and 22 percent respectively from 10 and 9 percent in 1994.

• Health instruction for middle school students increased with 78 percent of the schools requiring one-half year or more, compared to 66 percent in 1994.

Instructional Content

• A very high percentage of teachers continued attempts to increase student knowledge on a variety of health topics.

• A high percentage of teachers reported teaching a variety of skills in health education courses (e.g., decision-making, 98 percent; resisting social pressure for unhealthy behaviors, 97 percent; goal setting, 89 percent; stress management, 88 percent; communication, 87 percent; non-violent conflict resolution, 79 percent; and analysis of media messages, 75 percent).

• Significantly fewer teachers taught skills in 1994 (e.g., 69 percent taught decision-making and 53 percent taught communication skills to avoid HIV risk behaviors).

Teacher Preparation

• 40 percent of the teachers' major emphasis of professional preparation was in health and physical education. 90 percent were certified to teach health education. 61 percent had been teaching health education for more than five years. 49 percent had been in the teaching profession for 15 years or more.

• The most common inservices attended by teachers in the past two years were on CPR (51 percent) and alcohol and other drug-use prevention (41 percent).

• 34 percent of the teachers received four or more hours of inservice on HIV prevention during the past two years compared to 44 percent in 1994.

• Teachers' interest in receiving inservice increased overall from 1994, especially in the following topics:

	1994	1996
HIV Prevention	48%	67%
Suicide Prevention	44%	62%
Conflict Resolution / Violence Prevention	49%	56%
Alcohol and other Drug-Use Prevention	42%	54%

Discussion

Significant Changes from 1994

1. There was an increase in support for comprehensive health education as indicated by more schools identifying health education coordinators and through more involvement of parents, community members and students on advisory councils. Continued support is critical in order to have effective programs.

2. There was an increase in skills instruction. Research indicates that providing only factual information about health-related topics is not enough to influence student behavior. Therefore, it is essential for schools to continue to provide opportunities for students to learn health-enhancing skills which prepare them to make responsible decisions about their health.

3. There was an increase in teachers' desire for inservice in HIV, suicide, violence and alcohol-use prevention. This may indicate that teachers are concerned about the number of students who are engaging in health-risk behaviors. (The incidence of such behavior is well documented in the 1995 Missouri Youth Risk Behavior Survey.) Opportunities for teacher training and inservice should be continued.

4. Although there was an increase in required health education for 11th and 12th graders, the overall percent of secondary schools requiring comprehensive health education decreased. The Missouri School Improvement Program requires districts to provide comprehensive health instruction, including, specifically, drug and alcohol abuse prevention education and AIDS prevention education to all students at every grade level.

5. There was a decrease in the percentage of schools using trained peer educators. Research indicates that effective programs involve students in decisions about programs and allows them to present positive messages to their peers.

Conclusion

Secondary school personnel are to be commended for the strides which have been made in improving comprehensive health education. It is hoped that this report will encourage continued efforts to improve the health of Missouri students and enhance programs that reduce health risks for all young people.

Acknowledgments

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